



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS HEALTH DBA INJURY 1 DALLAS

Respondent Name

MEMIC INDEMNITY CO

MFDR Tracking Number

M4-14-2793-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MAY 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claims were recommended allowances but payment was never received."

Amount in Dispute: \$2,344.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's request was not date-stamped as received by DWC MRD until 5/8/14. Consequently, it is not timely as to the DOS prior to 5/9/13 at issue per Rule 133.307(c). The provider has failed to invoke the jurisdiction of DWC MRD as to these dates. Please dismiss...Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2013 April 5, 2013 May 29, 2013	CPT Code 90882 Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	\$150.00/each	\$0.00
February 13, 2013 February 19, 2013 March 5, 2013 April 11, 2013 April 16, 2013 May 2, 2013 May 9, 2013 June 14, 2013 June 21, 2013 June 25, 2013	CPT Code 90834 Psychotherapy, 45 minutes with patient and/or family member	\$131.75/each	\$527.00
March 13, 2013 May 10, 2013 July 2, 2013	CPT Code 96151 (X4) Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented	\$126.96/each	\$253.92

	questionnaires), each 15 minutes face-to-face with the patient; re-assessment		
June 14, 2013 June 21, 2013 August 9, 2013	CPT Code 90901 (X12) Biofeedback training by any modality	\$65.52/each	\$196.56
TOTAL		\$2,344.94	\$977.48

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Workers compensation jurisdictional fee schedule adjustment.
 - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
 - 151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
 - 298-Only one is allowed per date of service.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Does the documentation support billing code 90901? Is the requestor entitled to reimbursement?
3. Is the requestor entitled to reimbursement for code 90882?
4. Is the requestor entitled to reimbursement for codes 90834 and 96151?
5. What is the maximum allowable reimbursement (MAR)for the disputed services due the requestor?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are February 5, 2013 through August 9, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on May 8, 2014. Dates of service February 5, 2013 through May 2, 2013 are past the one year filing deadline. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section for dates of service February 5, 2013 through May 2, 2013; consequently, the requestor has waived the right to medical fee dispute resolution for these dates of service.
2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 90901 based upon reason code "151." The requestor billed for twelve units of CPT code 90901; however, the requestor is seeking dispute resolution for only one unit. The submitted reports support biofeedback services; therefore, reimbursement per Division rules and fee guidelines is recommended.
3. A review of the submitted documentation finds that neither party submitted explanation of benefits to support the denial of payment for code 90882.

CPT code 90882 is defined as "Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions; therefore, the disputed service will be reviewed per Division rules and fee guideline."

The May 29, 2013 *Environmental Intervention* report states "On behalf of psychiatric patient for the pupose(s) of: Peer reviewed request for psychological services for [Claimant] with Dr. Vreeland. We discussed patient's

treatment history, treatment, planning, RTW options, and current status (including current Beck scores). Additionally, we reviewed how patient would benefit from treatment. The patient's current status and progress in treatment were summarized. Determination was not provided." This report does not discuss if Dr. Vreeland was with what agencies, employers or institutions to support code 90882. The report also does not indicate what environmental changes were discussed for managing claimant's condition; therefore, the requestor has not supported billing CPT code 90882. As a result, reimbursement is not recommended.

4. According to the explanation of benefits, the respondent recommended payment for CPT codes 90834, and 96151. The requestor states in the position summary that "The claims were recommended allowances but payment was never received." No documentation was submitted by the respondent to support that payment was issued; therefore, reimbursement per Division rules and fee guidelines is recommended.
5. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
 (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.
 (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service 55.3.

The Medicare Conversion Factor is 34.023.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75243, which is located in Dallas, Texas; therefore, the Medicare locality is "Dallas, Texas."

Using the above formula, the Division finds the following:

Code	Number of Services from May 9, 2013 Through August 9, 2013	Number of Units Billed	Medicare Participating Amount	MAR	Insurance Carrier Paid	Amount Due
90834	4	1	\$81.06	\$131.75 X 4 dates = \$527.00	\$0.00	\$527.00
96151	2	4	\$19.53	\$31.74 X 4 units = \$126.96 X 2 dates = \$253.92	\$0.00	\$253.92
90901	3	12, but seeking MFDR for 1	\$40.31	\$65.52 X 3 dates = \$196.56	\$0.00	\$196.56

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$977.48.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$977.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	<u>02/20/2015</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.